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PTSD and Community-Based Treatment: A Commentary on "PTSD Diagnosis and Treatment for Mental Health Clinicians"

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Diagnostic concepts deserve our attention to the extent that they inform and enhance clinical practice, or facilitate research that in turn, will inform or enhance clinical practice. The specific clinical phenomena that were clustered together, in 1980, as diagnostic criteria for the DSM-III diagnosis of Posttraumatic Stress Disorder (PTSD) have been recognized for centuries. They have been described in both narrative fiction and in historical records since the time of Homer, and have been presented in the clinical psychiatric literature, since, at least, the latter part of the last century.

The important contributions of the *current* formulation of PTSD are richly reflected in the comprehensive and succinct overview presented by Dr. Friedman. The most important contributions of the current formulation of PTSD to the understanding and treatment of traumatic stress can be summarized in five points: (1) it has provided an operational definition of a clinical entity that is applicable to many clinical

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situations and that has become the subject of rigorous research; (2) it has validated the role of actual historical events in the genesis of some forms of psychological pain and social dysfunction, and showed that psychological injury can be as enduring in its effect as physical injury; (3) it has led to the recognition that traumatic exposure is far more common than had been believed, especially sexual assault and child abuse; (4) it has linked residual phenomena stemming from many different types of traumatic experience together so that they can illuminate each other, even as they remain different in many ways; and (5) it has encouraged the development of clinical approaches through which traumatic experience is recalled and relived in a safe and supportive setting to attenuate its pathogenic effect. As Dr. Friedman points out, PTSD is a conceptual tool that directs us to explore and validate, in detail, for the victim and for his or her loved ones, the authenticity and tenacity of traumatic experience. Finally, and perhaps most importantly, it has stimulated cross-fertilization of thought and collaborative research between clinicians and clinical researchers working with victims of many different types of catastrophic experience, among them war zone stress, rape, natural disaster, and bereavement.

The PTSD concept has served well as a guide to both treatment and research and has expanded our horizons in many ways. The publication of a summary of the state of the PTSD field in the *Community Mental Health Journal,* however, should draw attention to some of the *limitations* of PTSD treatment, as well, especially as they pertain to the treatment of seriously mentally ill people in community mental health settings. This commentary seems an apt occasion for outlining some of those limitations.

As the provider of last resort, the public mental health system takes (and is given) responsibility for serving people with the most disabling of mental health problems, people who face multiple difficulties in many areas of their lives. In addition to their physical and mental health problems, patients served in community mental health facilities often suffer from a variety of serious adjustment problems in the areas of employment, income, housing, and social support. Their lack of material resources, furthermore, often forces them to live in high-stress neighborhoods in which poverty, crime, drug abuse and violence are common, if not rampant. It seems ironic, at first, to suggest, that the PTSD concept may be less helpful with such people as compared to those whose lives are less troubled. In their exposure to a stigmatizing culture, to family and neighborhood violence, and, even to abuses at

the hands of the health care system, these patients are frequently exposed to trauma, and are likely to be particularly vulnerable to such experiences. It is, however, precisely the fact that they are more likely than others to live in an environment in which traumatic experiences are prevalent that distinguishes them from the types of victim more typically addressed by PTSD-oriented treatment.

One of the implicit features of the DSM-III formulation of PTSD, and of evolving treatment approaches to PTSD, is the assumption that the immediate danger has passed: the war is over, the rapist has fled, or conditions after the natural disaster have begun to resume their conventional shape. The goal of virtually all PTSD treatment is to help the victim "get over" traumatic residues and to experience a safety that is presumed to have been restored. Put somewhat differently, the goal of most PTSD treatment is to facilitate a return to a psychological equilibrium that is appropriate to what is assumed to be a relatively low level of actual danger.

For many seriously mentally patients seen in community mental health clinics, the danger only partially recedes after a traumatic incident. Whether the victimizer is an abusive husband, an unknown mugger, or a well-known drug gang in a deteriorating neighborhood, an aura of risk is likely to persist. For these patients a different type of treatment is needed: a treatment that acknowledges the *continuing* existence of the risk of traumatic experience and danger, and that focuses on the steps needed to minimize the risk of re-exposure to such experiences. An additional emphasis in these situations must be placed on practical externally oriented coping measures, in addition to insight, support and understanding. In such instances, the focus of attention must also be placed on adaptive issues of safety, housing, income, and social and family supports. Reverberating pain from past traumatic experiences may also need to be addressed, but the assumption of current safety and security can not be presumed.

A major objective of some programs of assertive community-based treatment is to help clients achieve a level of *actual* personal safety that they have not previously enjoyed. Whether the threat to their safety stems from their own self-destructive behavior, from tumultuous family relationships, or from actual neighborhood dangers, the mental health clinician in such assertive community-based programs must go beyond issues of psychological trauma to address the often very real dangers in a client's situation, either before, or in addition to, inviting exploration of residual memories of past dangers.